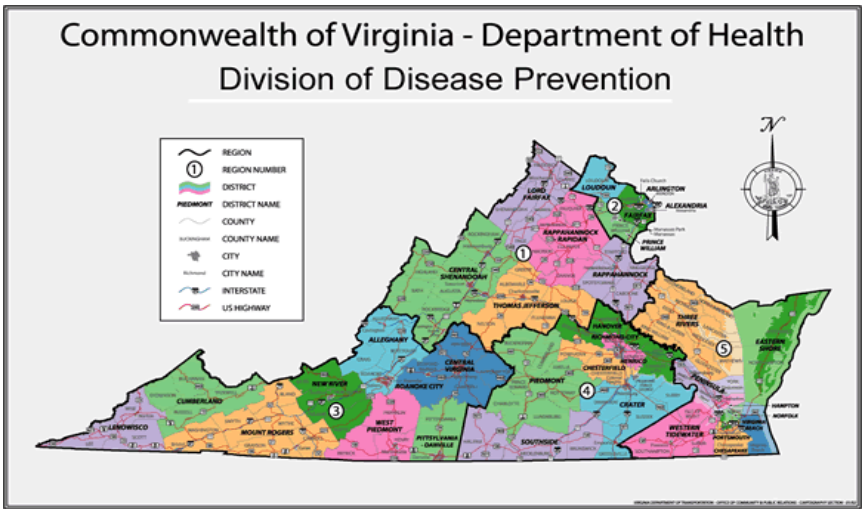
2012-2013 VIRGINIA COMMONWEALTH RYAN WHITE PART B

HIV QUALITY MANAGEMENT PLAN



PREPARED BY:
VIRGINIA DEPARTMENT OF HEALTH
DIVISION OF DISEASE PREVENTION
HIV CARE SERVICES UNIT

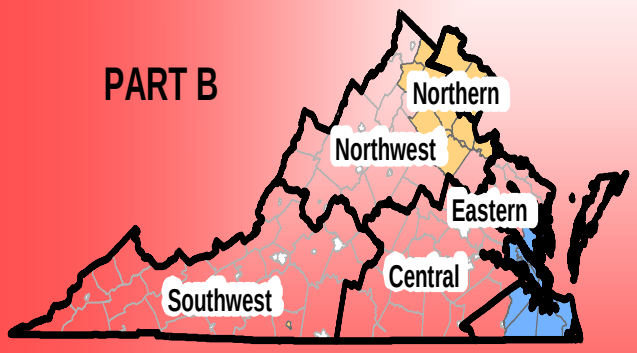
APRIL 2012

RYAN WHITE FUNDED AREAS IN VIRGINIA

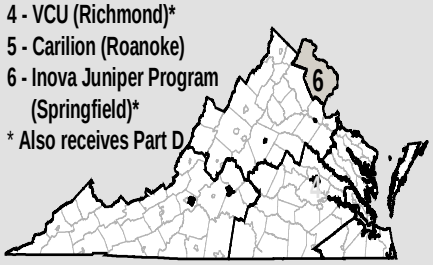
PART A LOCALITIES IN NORFOLK TGA

PART A N. VA LOCALITIES IN DC EMA

PART B



1 - UVA (Charlottesville)
2 - Mary Washington Hospital/Medicorp (Fredericksburg)
3 - Centra (Lynchburg)
4 - VCU (Richmond)*
5 - Carilion (Roanoke)
6 - Inova Juniper Program (Springfield)*
* Also receives Part D



PARTS C & D

Ryan White Part B Organizational Chart

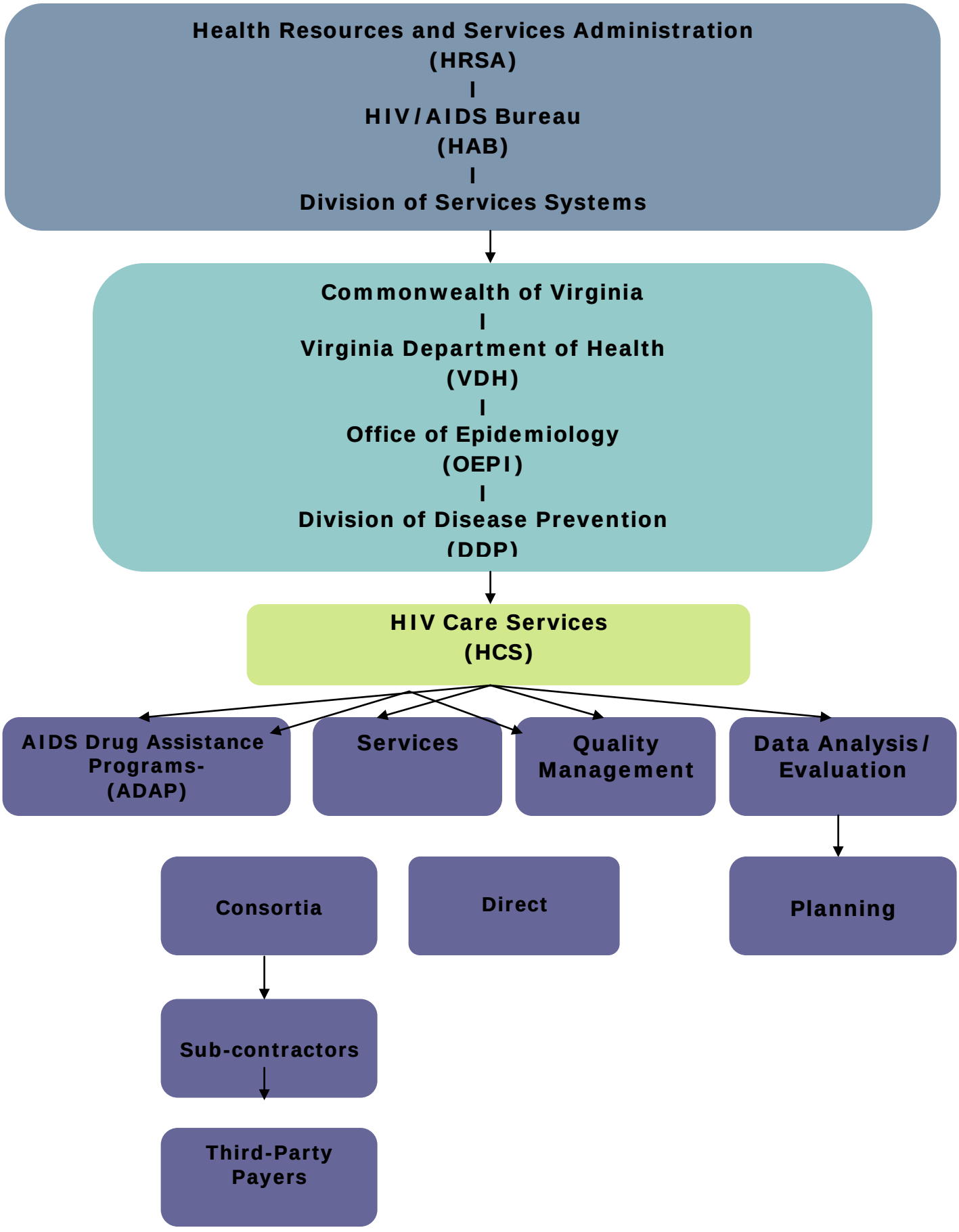


TABLE OF CONTENTS

LIST OF TABLES

ACKNOWLEDGEMENT

Thank you to the many people who contributed to this document. We acknowledge the Ryan White Part B (RWB) Quality Management Advisory Committee (QMAC) members who oversee the development of this document. Thank you to the Virginia Department of Health (VDH) – HIV Care Services (HCS) Quality Management Leadership Team (QMLT) members who consistently supported these efforts. We offer special acknowledgement to the work of Safere Diawara, HCS Quality Management (QM) Coordinator, who contributed content and coordinated the compilation of this Quality Management Plan (QMP).

The following individuals provided extensive time, effort and dedication to the development of this document:

Steven Bailey Director HIV Care Services Division of Disease Prevention Virginia Department of Health Phone: (804) 864-8065 Email: Steve.Bailey@vdh.virginia.gov	**Parrish F. Crosby** Peer Educator Eastern Region Phone: (757) 254-5466 Email: Parrishfc@att.net
Safere Diawara, MPH Assistant Director for HIV Services HIV Care Services Division of Disease Prevention Virginia Department of Health Phone: (804) 864-8021 Email: Safere.diawara@vdh.virginia.gov	**Cathy Fisher** Grant Monitor Southwest/Piedmont HIV Care Consortium Council of Community Services Phone: (540) 985-0131, Ext. 453 Email: cathyf@councilofcommunityservices.org
Fuwei Guo Quality/Data System Management Coordinator Virginia Commonwealth University Part C Program Phone: (804) 828-2417 Email: fguo@vcu.edu	**Heather Michael Bland, MSW** Medical Case Manager -Women's and Children's Care Program -Division of Infectious Diseases -Department of Pediatrics Office: 804.827.1678 Email: hmbland@vcu.edu
Tanya Kearney, MPA Director AIDS Resources and Consultation Center Eastern Virginia Medical School Phone: (757) 446-6170 Email: KearneTK@EVMS.EDU	**Robert Morrow** Director of Care Services Southwest/Piedmont HIV Care Consortium Council of Community Services Phone: (540) 985-0131 Ext 401 Email: Robertm@councilofcommunityservices.org

Gary Race Grants Administrator James Madison University Phone: (540) 568-8166 Email: racegs@CISAT.JMU.EDU	**Zachary Hatcher** Executive Director Fredericksburg Area HIV/AIDS Support Services Phone: (540) 371-7532 x. 11 Email: director@fahass.org
Adam T. Thompson Intervention Specialist Phone: (864)-354-8468 Email: adamtthompson@gmail.com	**Amelia Khalil, MA** Senior Contract Officer/Quality Manager Northern Virginia Regional Commission Phone: (703) 642-4643 Email: akhalil@novaregion.org
Lenore Lombardi Lead HIV Services Coordinator HIV Care Services Division of Disease Prevention Virginia Department of Health Phone: (804) 864-8022 Email: Lenore.Drewry@vdh.virginia.gov	**Anne Rhodes** Services Analyst HIV Care Services Division of Disease Prevention Virginia Department of Health Phone: (804) 864-8013 Email: Anne.Rhodes@vdh.virginia.gov
Catherine J. F. Derber, MD, FACP Assistant Professor Department of Internal Medicine Division of Infectious Diseases Eastern Virginia Medical School Phone: 757-446-8999 Email: DerberCJ@EVMS.EDU	**Tonya Pacelli, BA, CSAC** Medical Case Manager Vernon J Harris Medical Center 719 N. 25th Street Richmond, VA 23223 Office 804-253-1961 tpacelli@cahealthnet.org
Johanna T. McKee, RN, CCRC Site Director PAMA AETCLPS So. VA VCU HIV/AIDS Center Phone: 804-828-2430 (Office) Email: jmckee2@mcvh-vcu.edu	

Structure of the HIV Quality Management Plan

This document is organized into the following sections:

1. Introduction
2. Quality Statement
3. QM Infrastructure
4. Goal and Implementation Plan
5. Capacity Building
6. Performance Measurement
7. Participation and Communication with Stakeholders
8. QM Evaluation Plan
9. Process to Update the QMP
10. Communication

1. INTRODUCTION

The Ryan White (RW) Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) Treatment Extension Act of 2009 requires Clinical Quality Management (CQM) programs as a condition of grant awards. VDH is committed to improving the quality of care and services for people living with HIV and AIDS through continuous quality monitoring and improvement in a comprehensive performance measurement program. This effort requires ongoing communication with consumers, employees, stakeholders, QMAC, QMLT, Peer Review Team, contractors, subcontractors and all levels of management. The QM expectations for RWB Program grantees include:

- Assist HIV/AIDS service contractors and subcontractors funded through the RW Program in assuring that funded services adhere to established HIV clinical practice standards and Public Health Services (PHS) Guidelines to the greatest extent possible;
- Ensure that strategies for improvements to quality medical care include achieving appropriate access to HIV care and support for treatment adherence; and
- Ensure that available demographic, client satisfaction, clinical, and health care utilization information is used to monitor the spectrum of HIV-related illnesses and trends in the local epidemic.

The QMP reflects an ongoing improvement process, which also informs the delivery system of outcome results, demonstrating commitment to quality services for all individuals served within the Virginia RWB provider network. The QMP also guides root cause analysis and corrective actions for identified problems. To ensure a useful and current QMP, the QM Committees (QMC) will review the progress of the plan on a quarterly basis and conduct an annual review of the QMP.

The 2012 QMP was developed with input from stakeholders and consumers throughout Virginia and across RW Programs. This final approved document will be shared with all stakeholders and healthcare providers who care for PLWHA in Virginia. The Plan is available in print and on the following website:

http://www.vdh.virginia.gov/epidemiology/DiseasePrevention

This QMP is effective April 1, 2012. If you have any questions concerning this plan, please contact Safere Diawara, MPH, QM Coordinator at (804) 864-8021 or by email Safere.Diawara@vdh.virginia.gov

2. QUALITY STATEMENT

a. Mission Statement:

The Virginia RWB QM Program exists to ensure the highest quality medical care and supportive services for people living with HIV/AIDS in Virginia through statewide leadership and stakeholder collaboration.

b. Vision:

We envision optimal health for all people affected by HIV/AIDS, supported by a health care system that assures ready access to comprehensive, competent, quality care that transforms lives and communities.

c. Values:

We believe in creating HIV/AIDS services that inspire and promote:

- Mutual respect
- Safe and confidential environments
- Education to increase empowerment and self sufficiency
- Quality Improvement (QI) and accountability
- Creativity and innovation
- Diversity
- Cultural competency
- Community responsibility
- Wellness

d. Overall Goals:

The overall goal of the RWB QM Program is to monitor continuous quality improvement (CQI) activities of contractors and subcontractors providing services throughout Virginia. Other goals include:

- Assessing QM needs, educating service providers, and building capacity within RWB funded agencies statewide;
- Improving quality of care in meeting the service needs of clients statewide;
- Assisting providers in assuring adherence to PHS Guidelines;
- Improving existing databases and data management including outcomes data as well as needs assessment and client satisfaction data; and
- Improving access to and retention in care

e. Purpose:

The QM Program is designed to:

- Provide guidance, assistance, and educational activities related to QI, Quality Assurance (QA) and QM;
- Meet or exceed the QM expectations of current federal RW legislation;
- Assess the extent to which HIV health services provided to clients under the grant are consistent with the most recent PHS Guidelines for the treatment of HIV diseases and related opportunistic infections;
- Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to care and quality of HIV health services; and
- Promote commitment to quality of care throughout the RW continuum of care.

f. Aim Statement:

The aim of the QMP is to establish and maintain a seamless system of comprehensive HIV services that provides a continuum of care and eliminates health disparities across jurisdictions for the quality of life of people living with HIV/AIDS in Virginia. Additionally, the QM Program aims to continuously improve the quality of care and services of the HIV/AIDS programs provided by RWB providers and their partners and to be compliant with recognized treatment guidelines, standards of care, and best practices. This will be accomplished by:

- Developing and implementing a statewide QMP;

- Monitoring core performance measures across RWB recipients and sub-recipients; and
- Participating in national QM collaborative projects initiated by Health Resources and Service Administration (HRSA) and the National Quality Center (NQC) including the Patient Safety and Clinical Pharmacy Services Collaborative (PSPC), District of Columbia (DC) Eligible Metropolitan (EMA) Cross-Parts Collaborative, and the VA RW Cross-Parts Collaborative.

3. DEFINITION OF QUALITY

QI terminology is often used interchangeably. The following definitions can be found in the QM Technical Assistance manual developed by HRSA.

a. Indicator:
A measurable variable or characteristic that can be used to determine the degree of adherence to a standard or the level of quality achieved. Indicators serve as an interim step toward achieving a performance measure and are also referred to as activities.

b. Performance Measure:
Performance measure is a quantitative tool that provides an indication of the quality of a service or process. It is a number assigned to an object or event that quantifies the actual output and quality of work performed

c. Quality:
Quality is the degree to which a health or social service meets or exceeds established professional standards and user expectations. Evaluation of the quality of care should consider: The quality of the inputs, the quality of the service delivery process, and the quality of life outcomes.

d. Quality Management:
QM is a larger concept, encompassing continuous QI activities and the management of systems that foster such activities: communication, education, and commitment of resources. The integration of quality throughout the organization of the agency is referred to as QM. The QM Program embraces QA and QI functions.

e. Quality Assurance:
QA refers to a broad spectrum of ongoing/continuous evaluation activities design to ensure compliance with minimum quality standards. An ongoing monitoring of services for compliance with the most recent PHS guidelines for the treatment of HIV disease and related opportunistic infections, and adherence to State and federal laws, rules, and regulations.

f. Quality Improvement:
QI is generally used to describe the ongoing monitoring, evaluation, and improvement process. It includes a client-driven philosophy and process that focuses on preventing problems and maximizing quality of care. This focus is a means for measuring improvement to access and quality of HIV services.

g. Plan, Do, Study, Act (PDSA) Cycles:
The Virginia QI process is based on the PDSA cycle methodology. This model for performance improvement will be used for all QI activities:

- **PLAN** – Identify and analyze what you intend to improve, looking for areas that hold opportunities for change.
- **DO** – Carry out the change or test on a small scale (if possible).
- **STUDY** – What was learned? What went wrong? Did the change lead to improvements in the way you had hoped?
- **ACT** – Adopt the change, abandon it, or run through the cycle again.

h. Outcomes:
Results achieved for participants during or after their involvement with a program. Outcomes may relate to knowledge, skills, attitudes, values, behavior, conditions or health status.

i. Outcome Indicator:
Specific item of information that track a program's success (or failure) on outcomes. They describe observable, measurable characteristics or changes that represent the product of an outcome.

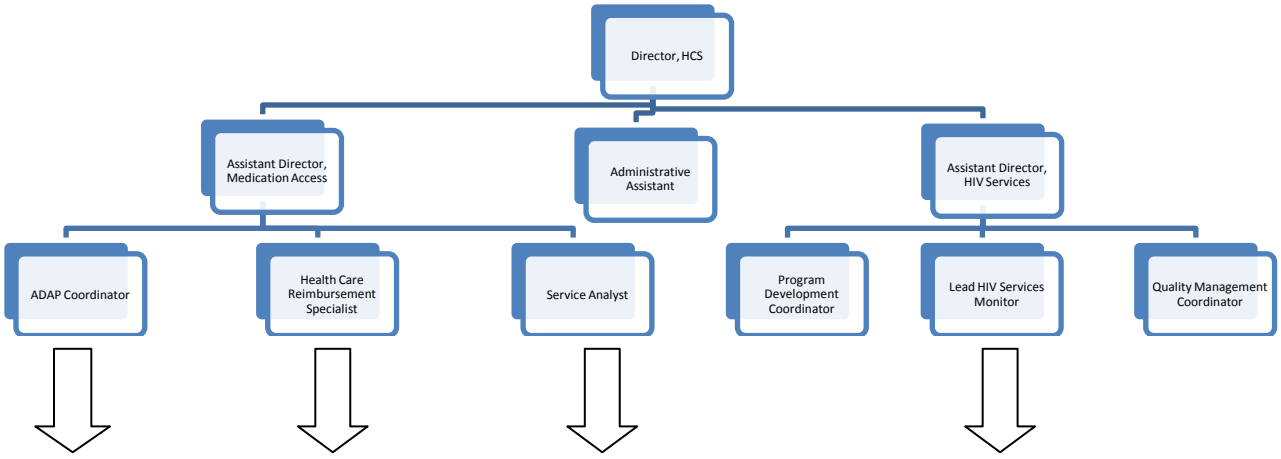
4. SCOPE OF RWB PROGRAMS

The Governor of Virginia (VA) has designated the Secretary of Health and Human Resources as the individual responsible for delegating responsibility for the administration of the RWB grant. The Secretary has designated the State Health Commissioner, to submit the grant application and administer these funds (designation letters available upon request). VDH, Division of Disease Prevention (DDP) carries out these functions under the Commissioner's authority.

Within DDP, the Director of Human Immunodeficiency Virus (HIV) Care Services (HCS) reports to the Director of DDP. The Director of HCS supervises two Assistant Directors of HCS and the Executive Secretary. The Assistant Director for Medication Access supervises the AIDS Drug Assistance Program (ADAP) Coordinator, the Healthcare Reimbursement Specialist and the HIV Services Analyst. The ADAP Coordinator supervises one ADAP Operations Specialist and 3 ADAP Services Coordinators who coordinate the Seamless Transition Program, medication exceptions, and daily ADAP operations support. These positions also monitor ADAP-funded service contracts. The HCS Services Analyst supervises the HIV Services Planner, ADAP Data Manager, and the Special Projects of National Significance (SPNS) Data Manager. The Assistant Director for HIV Services supervises the QM Coordinator, the Lead HIV Services Coordinator, and the Program Development Coordinator who manages all elements of grants management. The Lead HIV Services Coordinator supervises four HIV Services Coordinators/Contract Monitors (CM) that monitor over 30 contracts for Part B and state-funded contracts in all five health regions throughout the state.

Portions of positions assigned to other VDH units and departments are funded to provide additional support in administering Part B activities, including: the Office of Epidemiology's Administrative Deputy, HCS's Business Manager, a Medicaid back-billing manager, and a fiscal technician. Additionally, portions of the Pharmacy Director, three pharmacist staff positions from VDH Central Pharmacy, and two Pharmacist Assistants who are funded to dispense ADAP medications.

HCS Unit Chart:



Contract Staff (3)
ADAP Services Coordinators (3)
AOS (1)

Health Care Claims Specialist

HIV Services Planner
ADAP Data Manager
SPNS Data Manager

Service Coordinators (4)
SPNS Care Coordinators (2)

The RWB attempts to meet the complex needs of eligible persons living with or affected by HIV/AIDS. VDH provides core medical and support services for over 4,200 HIV/AIDS clients by funding four regional consortia, projects funded with a combination of Minority AIDS Initiative (MAI) and other funding and contractors under the Emerging Communities (EC) initiative. Additionally, HCS funds direct service agreements to provide medical care, core medical and support services, ADAP eligibility determination services, client-level database management, and specialized projects supporting linkage to care, adherence and improved care access. ADAP provides anti-retroviral medications, drugs used for the prophylaxis and treatment of HIV-related conditions and co-morbidities, Medicare Part D wraparound services, and conducts statewide centralized eligibility determination .

The RWB QM Program ensures that clients receive comprehensive care based on mandated guidelines, professional standards and best practices.

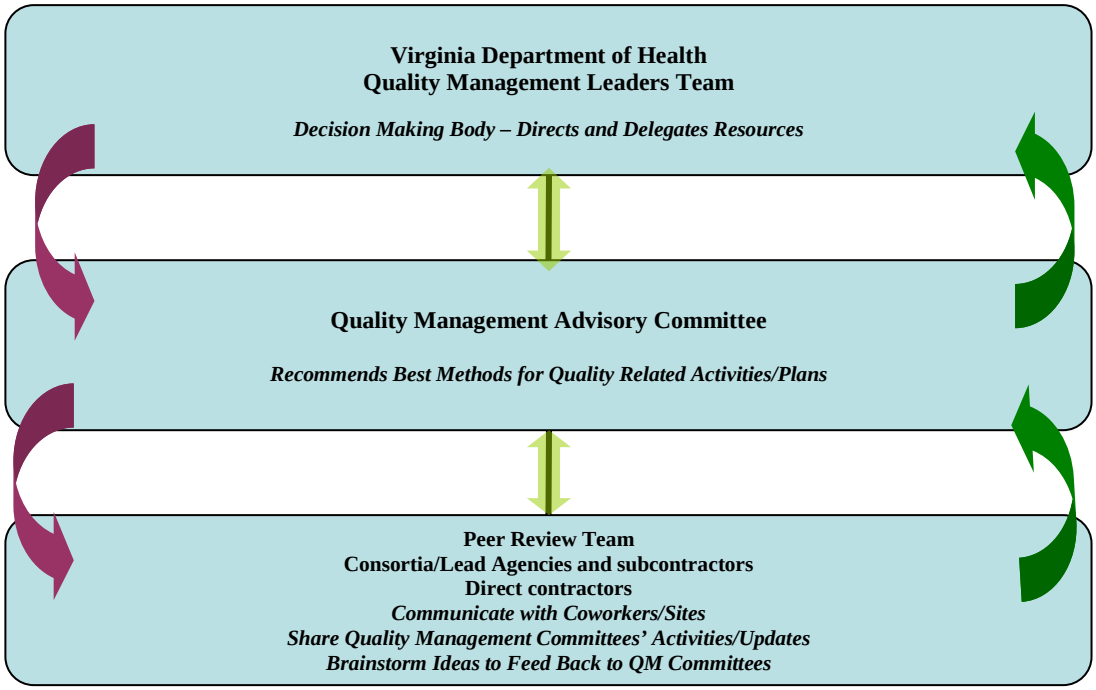
5. QUALITY IMPROVEMENT INFRASTRUCTURE

a. Leadership and Accountability:

- Health Resources and Service Administration (HRSA)
  An agency of the U.S. Department of Health and Human Services (DHHS) is the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable. HRSA writes and delivers guidance and expectations to grantees.

- VDH through the Division of Disease Prevention (DDP)
  VDH DDP provides leadership and support to local health departments, medical providers, and community-based organizations (CBOs) in the prevention, surveillance, and treatment of HIV and other sexually transmitted diseases, tuberculosis, and other

complications. It is also dedicated to the provision of education, information, and health care services that promote and protect the health of all Virginians. Additionally, DDP collaborates with the Central Pharmacy to ensure the provision of medications and vaccines through ADAP statewide.



- HCS Quality Management Coordinator

  Provides general oversight of the QM Program, coordinates all program evaluation and QM activities, oversees standards of care and outcomes measurement activities, analyzes outcomes data, and integrates the data into requested reports.

  The QM Coordinator reports to the Director of HCS, who assumes overall responsibility for the QM Program. The QM Coordinator primary responsibilities include:

  - Identifying QM team leaders and champions;
  - Ensuring development, implementation, and evaluation of the QMP;
  - Ensuring the development, implementation, and evaluation of statewide standards, modules, and other tools;
  - Delineating specific goals and responsibilities for the QM team members (e.g. development of the improvement project/PDSA test cycles, meeting facilitation, note taking, etc.);
  - Conducting coordinated QI projects at targeted program sites that are demonstrating lower performance on key indicators;
  - Developing a data collection plan for each project;
  - Identifying potential solutions for performance improvement on key indicators, including immediate and long-term solutions;
  - Providing QM technical assistance, training and support, as needed; and
  - Coordinating QMC meetings.

- The HIV/AIDS Data Team
  The HIV Services Analyst is responsible for managing the Virginia Client Reporting System (VACRS) and the Virginia ADAP database. The Services Analyst coordinates efforts with CAREWare users, Department of Medical Assistance Services (DMAS), and other DDP programs to generate data that supports QM efforts.

  The VACRS is a real-time, client-level database that links service providers together through the Internet. Data captured within the VACRS includes client intake information and encounter and medical update information for each client including demographics, co-morbidities, lab markers, service utilization data, and outcomes survey and assessment data.

- RWB Consortia , Direct Contractors, Subcontractors and Other Providers
  Each individual agency/program is responsible for its own QMP and is accountable to RWB to provide data, make improvements on areas of low performance, and to share QMPs with the QMCs.

b. Quality Management Committees:

1. Quality Management Leadership Team (QMLT)
   The QMLT is charged with providing leadership and oversight for all QI activities. The QMLT works closely with the QMAC to develop and implement the statewide RWB QMP, ensures adequate resources to carry out the annual QM work plan, and engages key stakeholders in the QM Program when appropriate.

   Membership of the QMLT consists of:

   - Director of HCS
   - Two Assistant Directors of HCS
   - ADAP Coordinator
   - Lead Contract Monitor
   - QM Coordinator
   - HIV Services Analyst

2. Quality Management Advisory Committee (QMAC)
   The committee provides oversight and facilitation of the Virginia RWB QM Program and provides a mechanism for review of objectives evaluation, and continuing improvement of HIV care and support services. The team membership will be reviewed annually and changes will be made accordingly.

   The Committee structure consists of:

   - Representatives from the five health regions
   - VDH- HCS QM Coordinator
   - QM Coordinators from local sites
   - Consumers
   - Data Managers

- Physicians
- Program Administrators
- Consortia lead agencies

The members will be responsible for:

- Developing priorities and setting QI goals;
- Using continuous improvement methodologies (Plan, Do, Study, Act);
- Providing feedback to address problems/concerns to improve the QM Program;
- Developing and coordinating implementation of the QM work plan;
- Reviewing the QMP on an annual basis and making recommended changes as needed;
- Participating in quarterly meetings to review system-wide QM issues/challenges and developing strategies to improve care;
- Planning and development of educational strategies for RWB-funded providers; and
- Participating in annual evaluation to review peer review outcome measure reports and determine statewide quality initiatives and performance indicators and goals.

Membership on the QMAC Team is open to all RW providers and consumers. Participating members who wish to serve on the QMAC must complete the application form or submit a letter of interest to the QM Coordinator. The QMAC members review all applications and selections will be made based on availability and experience.

Consumer Capacity Development Sub-committee Responsibilities:

- Providing an effective means of QI communication to the consumers;
- Serving in an advisory capacity and making recommendations to the Response Team and stakeholders; and
- Increasing public awareness of the status of the Collaborative activities; and providing input into identified QM Programs.

c. Quality Improvement Project Teams (QIPTs):

QIPTs will be ad hoc teams charged with making improvements in specific aspects of care delivery. Using accepted QI methods; the QIPTs identify and test potential care delivery strategies. Membership of the QIPTs is determined by the QMCs, which provide guidance and assistance as needed to the teams.

The QIPTs will assume the following responsibilities:

- Identifying and testing potential solutions for the QI projects identified by the Quality Committees through Plan-Do-Study-Act (PDSA) cycles;
- Sharing the results of the improvement project with the QMCs;
- Making recommendations for implementation and integration of successful improvements throughout the state; and
- Evaluating the team's work and the process upon completion of the QI project.

The composition of the QIPTs is dependent on the area of improvement selected. Membership should include, but not be limited to, program collaborators, consumers, community members, other individuals identified with relevant expertise, and RWB staff. Each QIPT will designate a team leader for the process. A QIPT work plan will identify the action steps to be taken, and the person(s) responsible for the identified activities. The Team will meet as often as necessary to accomplish the planned activities.

d. Professional Peer Review Team:

Peer review services will be put out for bid to cover grant year 2012 review cycle.

e. Dedicated Resources:

- HRSA, HIV/AIDS Bureau, QM Technical Assistance Manual, and other QI and outcome related documents located at http://hab.hrsa.gov/tools/QM.
- The National Quality Center of the New York State Department of Health will provide technical assistance, training, and QI resources as needed http://www.NationalQualityCenter.org.
- HIV Clinical Resource – New York State Department of Health AIDS Institute http://www.hivqual.org.
- The Local Performance Sites of the Pennsylvania/Mid-Atlantic AETC.
- Virginia Northern, Eastern and Central/Southwest HARCCs.
- The RWB QMCs and The Virginia RWB grant provides funding and personnel resources for QM Improvement.
- VDH HIV/AIDS Surveillance Unit.
- Consortia and direct providers.
- Epidemiology Profile for Virginia.

f. Meeting Schedule:

The QMLT will meet at least weekly after the staff meeting and as needed.
The QMAC Team will be meeting on a quarterly basis and the QM Coordinator will prepare and distribute an agenda prior to the meeting. Meeting minutes and work plan updates will be maintained and copies of the minutes will be disseminated to the members.

6. 2012-2013 WORK PLAN GOALS and IMPLEMENTATION

Client-level health outcome goals are based on HAB's HIV Performance Measures for Core Clinical and ADAP. Currently, the work plan specifies objectives and strategies for QM goals. The QMP includes a timeline that incorporates the development, implementation, and revision of the plan based on the RWB grant year. The work plan will be revised at least quarterly by the QMCs.

QM goals include:

Goal: A. Developing and implementing the 2012 RWB QMP.
Goal: B. Strengthening the existing HIV QM Infrastructure within the RWB to supports QI activities in Virginia.
Goal: C. Ensuring that primary care and health-related support services adhere to the most recent US Public Health Service guidelines, federal and state regulations.

Goal: D. Providing TA and training on an ongoing basis.
Goal: E. Facilitating the implementation of QI activities in provider agencies to meet annual quality goals.-

The attached Table 1 provides information about the implementation/work plan.

Accomplishing the activities within this plan will require coordinated teamwork efforts throughout the RWB Programs. All RW programs should become an integral component in conducting applicable activities to accomplish the comprehensive QM Plan objectives and key activities.

7. PERFORMANCE MEASUREMENT

The RWB program will use performance measurement data to identify and prioritize QI projects, to routinely monitor the quality of care provided to consumers, and to evaluate the impact of changes made to improve the quality and systems of HIV care.

The attached Table 2 provides information about the current available data that is being tracked and reported for selected clinical services in the RWB program to address HAB's Performance Measures.

a. Selected Measures:

Specific clinical and prevention indicators to be measured for the current year include:

1. Percentage of clients with HIV who had two or more CD4 T-cell tests within the year.
2. Percentage of clients with AIDS who are prescribed Highly Active Antiretroviral Therapy (HAART) within the year.
3. Percentage of clients with HIV who had two or more medical visits in HIV primary care setting within the year.
4. Percentage of clients with HIV and CD4 T-cell count < 200 prescribed Pneumocystis Pneumonia (PCP) prophylaxis.
5. Percentage of clients with HIV infection who received testing with results documented for Tuberculosis infection (TBI) since HIV diagnosis.
6. Percentage of clients with HIV infection (equal or greater than 18 years old) who had a serologic test for syphilis at least once during the measurement year.
7. Percentage of ADAP clients who are prescribed HAART within the year.
8. Percentage of ADAP clients who will complete at least one eligibility determination through newly implemented centralized eligibility determination system.
9. Percentage of RW HIV-infected medical case management clients who had two or more medical visits in HIV care setting in the measurement year.
10. Percentage of RW HIV-infected medical case management clients with AIDS who were prescribed a HAART regimen within the measurement year.
11. Percentage of RW HIV-infected medical case management clients with a viral load below 200 at last test during the measurement year.

b. Data Collection:

Data will be collected from a variety of sources and to the extent possible, existing data sources will be utilized from several sources including the VACRS, client interviews and

chart reviews. Individuals involved in the collection of data should receive appropriate training regarding their role, the confidentiality and security of data, and other ethical issues.

Data collection will include:

- Data required to determine client eligibility;
- Data required by funders;
- Outcomes data developed for specific programs;
- Client Satisfaction data;
- Data to assess the needs of people living with HIV/AIDS (PLWHA) in Virginia;
- Other data as QM activities require or deem necessary.

1. Strategies
   The data teams, staff from funded agencies, and peer review team will assist with data collection strategies.

   For each data collection activity scheduled in the QMP, a data collection plan will be developed that specifies:

   - The purpose of the data collection activity.
   - The measures and indicators to be collected.
   - The instruments and methods to be used to collect the identified data.
   - The analysis plan for the data.
   - The methods for monitoring data security to determine how and for how long the data instruments and databases will be stored.
   - How and to whom the findings will be reported.

2. Data sources
   The Virginia QM Program is responsible for the regular collection, analysis and reporting of QM data. This data includes, but is not limited to:

   - Chart abstractions from client medical records (Paper or electronic)
   - ADAP, clinical, and demographic databases
   - Client satisfaction surveys/interviews
   - Utilization patterns
   - Billing records
   - Focus group summary
   - Statewide Coordinated Statement of Need (SCSN)
   - CAREWare
   - Enhanced HIV/AIDS Reporting System (eHARS)
   - VACRS
   - Administrative/Programmatic monitoring tools
   - ADAP database
   - Unmet Needs
   - ADAP Eligibility Reporting System (AERS)

c. Reporting Mechanisms of Data:

Findings for QM activities will be reported in aggregate format, and will not include client-level data. Program-specific data reports may be directly provided to each program for the purpose of enhancing their QM Program.

The data collection efforts will:

- place as minimal a burden as possible on the sources;
- minimize any interference with the routine operations of provided services; and
- utilize existing data sources (including clinical chart abstraction and consumer interviews)

RWB contractors and subcontractors will be required to report data on these selected key performance indicators. Compiled findings will be shared with HIV providers, Consortia, VDH leadership, and others. The QM Coordinator will be responsible for overseeing and ensuring implementation of the established process.

The attached Table 2 provides currently available data that are being tracked and reported for all RWB services in Virginia. The Core Clinical Data have been selected from the recommendations of the HIV/AIDS Bureau.

8. PARTICIPATION OF STAKEHOLDERS

In addition to HRSA and the VDH- DDP HCS Unit, the following groups are stakeholders currently involved in Virginia RWB HIV care activities:

1. QM LT
2. QMAC
3. RW service providers through Consortia or via direct VDH contracts
4. Regional Consortia lead agents
5. VDH including Division of Disease Prevention
6. SERL (data team)
7. VA RW Cross-Parts Teams
8. ADAP Advisory Committee
9. QIP Teams (when constituted)
10. Local health districts (LHDs)
11. VDH Central pharmacy
12. Patient Services Incorporated
13. Consumer individuals or groups
14. Treatment community (practitioners providing health care to RW clients):
    - Dentists
    - Mental health and substance abuse practitioners
    - Private physicians
    - Pharmacists
15. Laboratory centers

As appropriate, stakeholders will be invited to QMC meetings and invited to participate on QI Project Teams. It is a goal of Virginia's Part B QMP to strengthen the existing HIV program infrastructure to support QI activities in Virginia.

Other goals for Infrastructure/Stakeholders are:

1. QM will become a part of RW care provision and will be employed in everyday work.
2. Buy-in from stakeholders will be developed and advanced by clarifying their roles.
3. Infrastructures and QM models that work in a specific geographic area and under certain conditions will be replicated elsewhere in the state where similar conditions exist.
4. Virginia Part B QM system will develop relationships and provide technical capacity to extract QM related data.

Consortia
Regional planning entities have been established to plan and administer some RWB services. A Consortium is generally an association of public and nonprofit private health care providers, support service providers, community-based organizations, community members, and individuals infected and affected by HIV/AIDS. The Consortium analyzes gaps in medical and support services in its area and develops a comprehensive plan to address these gaps. They are responsible for:

- Ensuring QM components of the grant agreements are met.
- Participating in the statewide RWB QM Program including peer review and VDH site visits.
- Monitoring performance measures as determined by the QMCs.
- Providing information related to the local QM Program as requested by VDH.
- Ensuring all RWB providers use the statewide standards and modules.

Consortia Lead Agencies
There are four regional lead agencies in Virginia responsible for contract administration. A lead agency may be a public agency, service provider or a non-profit organization.

The lead agency conducts or updates an assessment of HIV/AIDS service needs for their geographical area, establishes a service delivery plan based upon prioritized services, coordinates and integrates the delivery of HIV-related services, assures the provision of comprehensive outpatient health and support services, evaluates the consortium's success in responding to service needs, and evaluates the cost-effectiveness of mechanisms used to deliver comprehensive quality of care.

Service Providers
Service providers are the agencies that provide direct services to clients and their families. These service providers may be directly funded by a contract or Memorandum of Agreement (MOA) with VDH or through sub-contracts with consortia lead agencies. Laboratory providers provide rapid, cost-efficient diagnostic laboratory testing services to support client care activities in many programs.

Third Party Providers
Third party service providers are paid on a fee for service (FFS) basis and provide client level information. Provision of services to PLWHA often requires the services of third parties ("business associates") to conduct operations. A business associate is a person or entity that

creates, receives, maintains or transmits protected health information (PHI) on behalf of the agency.

Consumers
Consumers are equal partners in the QI process and as such are sought as active members of any QI initiative related to the Collaborative. Consumers of all HIV-related services are the primary driving force behind the need for continual monitoring, re-evaluations and improvement of those services, the QMAC includes consumer representation to advise other members on QI processes. Meaningful consumer involvement reflects an integrated process rather than parallel consumer improvement activities. To that end, VDH felt the need and saw value in the inclusion of consumer representation from the inception of the Collaborative and moving forward.

Eligible clients are individuals and families who are infected and/or affected by HIV disease and meet program income eligibility requirements. Proof of HIV diagnosis is required. Appropriate documentation of proof is defined in the "Policy on Diagnosis Documentation" developed by HCS. This policy may be obtained through HIV Services Coordinators if needed. Income eligibility requirements are updated annually and may be accessed through the VDH DDP website at http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/HCS/

The benefits of involving people infected or affected with HIV in their own care are well documented. Active participation in treatment decisions encourages health-promoting behaviors and reduces behaviors that have serious health consequences for PLWHA and their partners. PLWHA provide valuable information for helping us to meet the challenges of planning and service delivery.

Affected Individuals
The HIV/AIDS pandemic has affected the lives of individuals, families, and communities around the globe. This infectious disease with its many complications has disproportionately affected individuals and communities with limited resources. Individuals who are HIV-affected are not HIV-positive themselves, but are heavily impacted due to the HIV-infection of a family member, friend, or loved one.

Local Health Districts and Field Services
LHDs and Field Services staff provides many services including medical, outbreak investigation, support services, health screening services, report investigations, immunizations, and HIV testing and counseling services. These providers report client-level data to VDH on an ongoing basis.

Virginia Commonwealth University Survey Evaluation and Research Laboratory (SERL)
Through its Part B funded MOA with VDH, the VCU SERL, provides data management support including all ADAP and Part B services data. It is responsible for ensuring accuracy of data collection methods and reporting to the HRSA as well. The team is responsible for maintaining the VACRS, importing data from CAREWare and other databases, generating QM-related reports, submitting required performance measures data reports, and assisting with other data needs.

Regional HIV/AIDS Resource and Consultation Centers (HARCCs)
The three HARCCs collaborate with the Pennsylvania/MidAtlantic AIDS Education and Training Center (PAMAAETC) to expand quality care for persons living with HIV/AIDS and to

focus on care and prevention through multidisciplinary educational programming for healthcare providers in Virginia.

The Tuberculosis Control (TB) and Prevention Program
The purpose of the Tuberculosis Control and Prevention Program is to control, prevent, and eventually eliminate TB from the Commonwealth of Virginia. The program utilizes variety of strategies designed to detect every case of TB that occurs in Virginia, and assures that every case is adequately and completely treated, and prevents additional transmission of the disease in communities. The TB Control and Prevention Program provides services to LHDs, health professionals in the private sector, laboratories and individuals impacted by TB.

Prevention Providers
Sexually transmitted disease (STD) and HIV prevention program providers develop comprehensive strategies to prevent the spread of STDs in Virginia. Some programs operate an outreach testing program that provides testing for gonorrhea, Chlamydia, syphilis and HIV in areas of high morbidity throughout Virginia. They report data to the VDH. Outcomes of their activities are reported monthly, including the percentage of people who test positive among the testing population.

The Virginia Local Performance Sites of the Pennsylvania Mid-Atlantic AIDS Education and Training Centers (PMAETC)
The PMAETCs provide HIV/AIDS-related training and technical assistance to healthcare providers in Delaware, the District of Columbia, Maryland, Ohio, Pennsylvania, Virginia, and West Virginia. They are part of a nationwide network of 11 AETC's funded by the Health Resources and Services Administration (HRSA) and US Department of Health and Human Services (DHHS), the purpose of the project is to increase providers' capacity to provide high quality HIV/AIDS care within the regions healthcare systems.

Patient Services Incorporated (PSI)
For nearly two decades, PSI has helped people who live with certain chronic illnesses or conditions locate suitable health insurance coverage and access ways to meet expensive co-payments. PSI provides assistance with the cost of health insurance premiums, HIPAA conversion policies; and prescriptions co-payments associated with private insurance and Medicare Parts B and D. VDH contracts with PSI to manage the centralized ADAP eligibility determination program and Medicare Part D wraparound assistance.

9. EVALUATION

Accomplishing the activities within the comprehensive QM program will require coordinated teamwork throughout the state, which will be facilitated by the QM Leadership Team and the QMAC. Monitoring will be conducted on a regular basis on the following items: QM Comprehensive Plan, Standards, Modules, Outcomes, achievements of goals and objectives, and clients' satisfaction and dissatisfaction. Data from these sources will be used by the statewide QM teams to plan, design, measure, assess and improve quality of services and processes. QI activities will examine and modify existing process if needed to address quality challenges.

a. Site Performance Measures:

Specific quality indicators will be reviewed for appropriateness and continued relevance. Upon completion of the annual review, a new set of quality indicators will be identified, goals for the upcoming year established, and specific quality initiatives will be identified in the updated QMP. Data will be compared internally with established standards and identified best practice organizations and guidelines.

b. Site Visits:

Peer Review Site Visits (including chart reviews and client interviews) are performed on an every other year basis for each selected health-related services delivery agency. Findings from those reviews will be used to assist in the development of agency specific QMPs and corrective action plans. Agencies review the results from their site visit reports and identify areas in need of improvement.

- Selected charts are reviewed to ensure that all supporting documents indicated in the modules are in place, are current, and meet funding source requirements for each service in the review sample. Additionally, other issues discovered in the process of reviewing the identified services may expand the scope of the review.

- All programs that have deficiencies will be required to complete a corrective action plan. This plan will specify how the provider will correct deficiencies. The plan is due to the QM Coordinator within 30 working days from the date that the site received the report. Technical assistance may be requested to assist with the development of the corrective action plan.

c. Client Interviews:

Client interviews will provide additional information regarding how well organizations are meeting consumers' expectations and information pertinent to the organization's QI efforts.
Each RWB funded provider is contractually required to measure client satisfaction. This methodology employs the use of a Peer-Administered Survey tool with questions that address the service, the provider and the Part B system as whole.
Performance is measured by indicators utilizing the following components:

- Efficacy: The degree to which the care for the consumer results in the desired outcomes.
- Appropriateness: The degree to which the care provided is relevant to the consumers' needs.
- Effectiveness: The degree to which the care is provided, in the correct manner, utilizing best practices and producing the desired outcome for the consumer.
- Continuity: The degree to which care is coordinated among practitioners, among organizations and over time.
- Safety: The degree to which an intervention reduces risk to consumers and others.
- Efficiency: The relationship between outcomes and the resources used to deliver consumer care.
- Respect: The degree to which consumers and their families (when appropriate) are involved in care decisions with sensitivity and respect for the consumers' abilities needs, expectations, preferences and cultural differences.

- Satisfaction: The services are provided in response to consumer strengths, needs, abilities and preferences.

d. Quality Management Plan:

RWB Grantee will evaluate the QMP on an annual basis, including rating the completeness of goals and key activities undertaken during the year, and results will be used to:

1. Determine the effectiveness of the QM Plan infrastructure and activities;
2. Review annual goals, identify those that have not been met, as well as the reasons these goals were not met, and assess possible strategies to meet them before the next review; and
3. Review the selected quality indicators for appropriateness and continued relevance in order to reach optimal care for consumers.

Based on the findings, VDH will refine strategies for the following year. Regular feedback regarding overall QI is critical in sustaining improvements over time. To obtain feedback from stakeholders:

- VDH will communicate findings and solicit feedback from key stakeholders on an ongoing basis and data presentations will be made during identified meetings.
- Written reports will be shared with stakeholders who will be given the opportunity to provide feedback on the reports.

Overall, the evaluation will strengthen organizational performance through process and outcome measurement, and link organizations to operational decision-making within the state system. Plan, Do, Study, and Act cycle is a way of continuously checking progress in each step of the focus process. This process will assist teams in focusing on specific improvement activities. Findings and revised QMPs will be submitted to VDH leadership for approval on an annual basis.

10. CAPACITY BUILDING

RWB will continue to build QI capacity through providing training, TA, and technology transfer. Capacity building needs will be determined through organizational assessments, QM surveys and focus groups. In partnership with various stakeholders, RWB QM Coordinator will develop and conduct comprehensive trainings for providers, consumers and advocacy committees regarding each element of the QM Program. Training will involve the development and delivery of curriculum and the coordination of training activities to increase the knowledge, skills and abilities of trainers, HIV service providers and consumers.

Also, RWB Grantee will also provide multiple QM ad hoc TAs that may be requested by individual agencies. The QM staffs will participate in the National Quality Center (NQC) and other RW QM trainings offered for grantees as needed. VDH will have several consultative meetings with providers and QMCs on process and systems issues identified from chart abstraction and/or database outputs and offer recommendations and technical assistance for performance improvement. Once opportunities for improvement have been identified, a multidisciplinary team will be convened (QI Project Team) to analyze the process and develop improvement plans.

All stakeholders including employees, consumers, QM Advisory Committees, volunteers and others within the RWB Program will be encouraged to attend at least one yearly training opportunity related to QM, process management, leadership development, problem solving, and/or team building.

VDH will have a role in:

- Setting direction and performance goals through strategic planning.
- Reviewing the QM overall performance in relation to established expectations.
- Ensuring resources necessary to continuously improve services will be identified for each issue and made available for issue resolution.
- Ensuring staff will receive the necessary training to remain current in the field healthcare services and provide quality services to the consumer population.

11. PROCESS TO UPDATE THE PLAN

The changing HIV epidemic may require a change in methods or processes to ensure the needs of the clients are being met.

The QMCs will review the progress of the QMP on a quarterly basis. Annual review of the plan will focus on the following areas: Mission, Vision, Values, Strategic Plan, Client Needs, Community Needs, Agency Needs, Performance and Outcomes.

At the beginning of each grant year, the QMCs will:

- Collaborate to establish a timeline for collecting, reporting and analyzing QM data.
- Complete the checklist to help review and identify opportunities for improvement to the QMP.
- Bring proposed QI projects and performance measurements to the attention of RWB stakeholders.
- Utilize available data/information to update the 2012 QMP.

All revised plans are to be completed and submitted through the QMAC and QMLT for approval before implementation.

12. COMMUNICATION

a. <u>Communication will be necessary with the following groups</u>:

- Contract and subcontract HIV service providers;
- Advocacy groups, AIDS or health care focused policy committees, RW leadership, NQC and HRSA staff ; and
- Consumers of RW services, etc.

b. <u>The purpose of communication will depend upon the group and may include</u>:

- Routine meetings to encourage buy-in of non-participating providers to join and provide their data to feed quality measurements;
- Responding to requests for information;
- Data gathering;
- Responding to results of PDSA Cycle and to implementation of other quality processes;
- Reports tied to output or outcomes more than process;
- Routine leadership communication, such as meeting minutes;
- Outcomes of QI activities; and
- Written information for audiences of varying education levels and competencies.

c. <u>The frequency of communication will depend upon the group and may occur</u>:

- On a routine basis, monthly or bi-monthly; more frequently during PDSA Cycles;
- On a monthly routine basis to describe processes and outcomes, report successes and challenges, and respond to TA needs;
- As needed to share information on outcomes; and
- Monthly for data submission and feedback.

d. <u>Open Meetings</u>:

Highly structured meetings such as the Collaborative Learning Sessions (LS) and QM Summit will be open to all RW providers, consumers and stakeholders and all are encouraged to participate. Statewide communication of QM activities is critical to ensure the success of excellent performance. Effective communication of goals, activities and progress fosters enthusiasm and motivation for all stakeholders to become more involved. Communication is essential to enhance the understanding of providing quality service among staff, clients, and other stakeholders.

To facilitate effective communication, several technological capabilities will be used including web sites, webinars, emails, and conference calls and/or meetings.

- The QMAC will meet at least quarterly.
- Conference calls and electronic communication - ongoing.
- The QMCs will communicate findings and solicit feedback from internal and external key stakeholders on an ongoing basis.
- Stakeholders will have the opportunity to provide feedback to reports and to assist with prioritizing quality activities.

The QMCs will establish linkages with key stakeholders to ensure that they have access to QM technical assistance. They will provide continuous skill-oriented interactive training programs for all staff regarding current guidelines, and incorporate consumers into planning and decision support.

Methods for distribution of the approved QMP include:

- Public Documents
- Websites
- Newsletters
- Trainings through VDH/HARCCs

e. <u>The form(s) of communication depend upon the group with which we communicate</u>.

- Contract and Subcontract Service Providers, and Consumers
    - Introduction to QI activities
    - Routine meetings to develop buy-in to provide data for quality measurements
    - Requests for information and data gathering
    - Response to results of PDSA cycles and implementation of other quality processes
    - Introduction to the work of the QMCs
    - Press-release style updates as projects progress
    - Reports related to output and outcomes
    - Quarterly consortia conference calls (held with VDH team)
    - Quarterly ADAP Advisory Committee meetings
    - Quarterly HCS Unit contractors meetings
- National Quality Center, HAB staff
    - Updates on QI activities
    - Requests for trainings and technical assistance
- VDH and HRSA Project Officers
    - Introduction to QM activities
    - Reports related to significant output or outcomes
    - Requests for feedback through phone calls, emails or written documents.

f. <u>The timing of communications depends upon the group with which we wish to communicate</u>.

- Subcontract service providers:
    - Routine, monthly, or bi-monthly interaction; more frequently during PDSA testing cycles.
- RW Consortia, advocacy groups, local health directs, community at-large:
    - Release DDP E-Bulletin when there are interesting outputs or outcomes to Report.
    - Delivery of “news” at local meetings including awards, outcomes, and significant VDH updates etc.
- National Quality Center and HAB staff:
    - Routine, monthly interaction describing process, outcomes, successes, challenges, and technical assistance needs.
    - Outcomes, when available.
    - VDH and HRSA Project Officers:
    - Routine monthly calls, or as needed.

13. COORDINATION WITH OTHER STATEWIDE QM ACTIVITIES

a. Coordination across RW Programs:

- The RWB QMP will focus on collaboration of quality activities for all RW Programs in Virginia.
- The RWB QMP includes participation of members from RW Part A, B, C, and D.
- The RWB QMCs will share results and best practices with the Virginia RW Cross-Parts Collaborative, Eastern Virginia Medical School Patient Safety and Clinical Services Collaborative projects, and DC EMA Cross-Parts Collaborative.

b. Coordination within VDH:

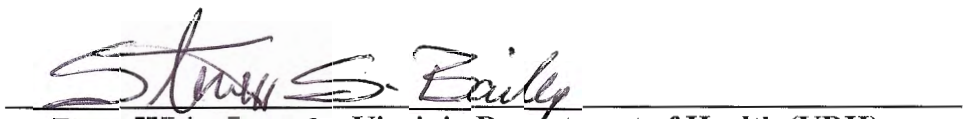
- HCS QM Coordinator will encourage and support the VDH Partnership.
- The HCS QM Coordinator will encourage the expansion of QI/QA efforts to include an interdisciplinary approach.
- The HCS QM Coordinator will collaborate with other units of the VDH/DDP on performance measures and shared quality findings.

c. Coordination with ADAP:

- The ADAP Data Coordinator is a member of the QMAC and QMLT.
- The RWB QMP includes input from ADAP providers and consumers.

APPROVAL OF 2012 QUALITY MANAGEMENT PLAN

This plan has been reviewed and approved by the RWB grantee as listed below. The annual QM Work plan must be reviewed and updated by April 30th each year. This plan will expire March 31, 2013.



Ryan White Part B – Virginia Department of Health (VDH)
Steven S. Bailey
Director HIV Care Services
Division of Disease Prevention

Adopted: ✓ **April 2012**
(date)

Review Annually on: ✓ **April 2012**
(date)

Dates (s) Reviewed: ✓ **April 2012**
(date)

The work plan will include goals, areas, objectives, key actions, responsible persons and/or parties, reporting methods, timeline, and status/follow-up.

The overall goals of the Virginia RWB Program are to increase the quality of care for eligible clients with HIV/AIDS clients and to create a system to monitor continuous improvement.

TABLE 1: IMPLEMENTATION/WORK PLAN FY2012-2013

Goal: A. Develop and implement the 2012 RWB QMP and work plan

Areas	Objectives	Key action steps	Person/Agency Responsible for Collection	Method of Reporting/Data Sources	Timeline
QMP	Evaluate 2011QM Plan And update 2012 Annual QMP as needed	Evaluate 2011 QMP	VDH QM Coordinator QMAC/ QMLT	Read document and submit suggestions	Submitted by March 31, 2012
		Edit 2012 QMP based on feedback from QMCs	VDH QM Coordinator	Write and incorporate submitted feedback	April 2012
		Approval process of the QMP by VDH and post it on VDH website	HCS Director	Approval notice.	April 2012
	Implement QMP	Require RW funded agencies to have in place an annual QMP and incorporate performance goals into their agencies' QI activities	A written QMP must be available for review at the provider location during site visits	Number and percent of RW Programs with QMPs	By March 2013
			Provide technical assistance as needed on writing a QMP	QM Coordinator	Ongoing
			All contractors are encouraged to submit performance measures indicators update information with their monthly or quarterly reports	Monthly or Quarterly QI activities - reports	Along with required reports
		Monitor implementation of QMP through on-site	HCS staff	Site visit reports, VACRS, and	Ongoing

		visits, performance measures data analysis and reports documents		Performance measures data analysis Submitted reports	
	Evaluate QM Program.	Submit final report on QI activities at the Quality committees' end of year meeting.	All RWB funded agencies and QM Coordinator.	End of year final reports.	May 2012
		Develop HRSA required reports.	VDH QM Coordinator.	Grant application Semi-annual Annual reports	January 2012 November 2012 June 2013

Goal: B. Strengthen the existing HIV QM Infrastructure within the RWB that supports QI activities in Virginia.

AREA	Objectives	Key action steps	Person/Agency Responsible for Collection	Method of Reporting/Data Sources	Timeline
Infrastructure QM Leadership Team (VDH)	Provide leadership and oversight for all QI activities.	Work closely with the QM stakeholders to develop 2012 QMP.	HCS Staff and stakeholders.	Approved QMP.	April 2012
		Implement the 2012 RWB QMP.	All stakeholders.	Ongoing reports.	By March 2013
	Strengthen collaboration within DDP Partnership to share Programs, policies, and best practices.	Use Established DDP Partnership infrastructure.	HCS QM Coordinator and other DDP staff.	Conjoint documents, policies, data sharing friendly guide, and procedures.	Ongoing
QM Advisory Committee	Provide oversight and facilitation of the Virginia RWB QM Program.	Develop priorities and set QI goals for 2012.	All team members.	Meetings Written documents Results analysis and different reports.	April 2012
		Expand membership to include other representatives.	All stakeholders.	Membership list Attendance to required activities.	By March 2013
QI Project Teams (QIPT)	Make improvements in specific aspects of care delivery.	Create ad hoc QI Project and Teams as needed.	Project Team Members and QMCs.	QI project reports	As needed by March 2013
Peer Review Team	Assess 50% of RWB funded providers' compliance with relevant standards of care	Examine client's charts for adherence to the Standards of care as	Selected contractor.	Site visit reports including strengths, area for improvement,	By March 2013

		required by HRSA and the state.		deficiencies, performance measures and recommendations.	

Goal: C. Ensure that primary care and health-related support services adhere to the most recent US Public Health Service guidelines, federal and state regulations

Area	Objectives	Key action steps	Person/Agency Responsible for Collection	Method of Reporting/Data Sources	Timeline
Performance measures	75 percent of RW clients with HIV will have 2 or more CD4 T-cell completed in the measurement year.	Clinical chart abstractions, site visits, client interviews, data collection, client satisfaction surveys.	VCU-SERL and all interested stakeholders.	VACRS CAREWare Database ADAP Database.	April/May 2012 Semi-annual – Nov/Dec 2012 Annual – May/Jun 2013
	90 percent of RW clients with AIDS will have prescribed HAART.	Clinical chart abstractions, site visits, client interviews, data collection, client satisfaction surveys.	VCU-SERL and all interested stakeholders.	VACRS CAREWare Database ADAP Database.	April/May 2012 Semi-annual – Nov/Dec 2012 Annual – May/Jun 2013
	95 percent of RW clients with HIV will have 2 or more medical visits in HIV setting.	Clinical chart abstractions, site visits, client interviews, data collection, client satisfaction surveys.	VCU-SERL and all interested stakeholders.	VACRS CAREWare Database ADAP Database.	April/May 2012 Semi-annual – Nov/Dec 2012 Annual – May/Jun 2013
	75 percent of RW clients with HIV and CD4 T-cell count <200 will have prescribed PCP prophylaxis.	Clinical chart abstractions, site visits, client interviews, data collection, client satisfaction surveys	VCU-SERL and all interested stakeholders.	VACRS CAREWare Database ADAP Database.	April/May 2012 Semi-annual – Nov/Dec 2012 Annual – May/Jun 2013
	100 percent of RW Clients with HIV infection will receive testing with results documented for Tuberculosis infection (TBI) since HIV diagnosis.	Clinical chart abstractions, site visits, client interviews, data collection, client satisfaction surveys.	VCU-SERL and all interested stakeholders.	VACRS CAREWare Database ADAP Database.	April/May 2012 Semi-annual – Nov/Dec 2012 Annual – May/Jun 2013

	80 percent of RW Clients with HIV infection and 18 years old or older will have a serologic test for syphilis performed within the measurement year.	Clinical chart abstractions, site visits, client interviews, data collection, client satisfaction surveys.	VCU-SERL and all interested stakeholders.	VACRS CAREWare Database ADAP Database.	April 2012 July 2012 October 2012 January 2013
ADAP	95 percent of ADAP clients will be prescribed a HAART regimen within the measurement year.	Clinical chart abstractions, Data entry into the VACRS.	VCU-SERL.	VACRS CAREWare Database ADAP Database.	April 2012 July 2012 October 2012 January 2013 April 2013
	95 Percent of ADAP clients will complete at least one eligibility determination through newly implemented centralized eligibility determination system.	Data entry and monitoring into ADAP Eligibility Reporting System (AERS) and VACRS.	PSI & SERL.	AERS VACRS.	April 2012 July 2012 October 2012 January 2013 April 2013
Medical Case Management	80 Percent of RW HIV-infected medical case management clients who had 2 or more medical visits in HIV care setting in the measurement year.	Clinical chart abstractions, site visits, client interviews, data collection, client satisfaction surveys.	VCU-SERL and all interested stakeholders.	VACRS CAREWare Database ADAP Database.	April 2012 July 2012 October 2012 January 2013
	80 Percent of RW HIV-infected medical case management clients with AIDS who were prescribed a Highly Active Antiretroviral Therapy (HAART) regimen within the measurement year.	Clinical chart abstractions, site visits, client interviews, data collection, client satisfaction surveys.	VCU-SERL and all interested stakeholders.	VACRS CAREWare Database ADAP Database.	April 2012 July 2012 October 2012 January 2013
	80 Percent of RW HIV-infected medical case management clients with a viral load below 200 at last test during the measurement year.	Clinical chart abstractions, site visits, client interviews, data collection, client satisfaction surveys.	VCU-SERL and all interested stakeholders.	VACRS CAREWare Database ADAP Database.	April 2012 July 2012 October 2012 January 2013
Data Collection and Reporting Process	Ensure completeness in statewide data.	Selected performance indicators and measures will continue to be tracked during the year	Requires all sites to report on selected measures and indicators	VACRS Previous data reports ADAP Database Peer Review reports	Ongoing and by March 2013
		Import data from CAREWare and other data systems into VACRS.	VCU-SERL collaborates with several providers.	VACRS CAREWare Database ADAP Database.	Ongoing and by March 2013

	Strengthen strong data QA activities.	Ensure error reports for each provider site to indicate whether requirements for client level data reporting and aggregate level data reporting are met.	VCU-SERL.	VACRS CAREWare Database ADAP Database.	Ongoing and by March 2013
		Monitor the client data records – Percent of HRSA required clinical indicators that met threshold for completeness in calendar year (% known must be 95% for labs and 50% for all other indicator) and provide quarterly feedback to providers	VCU-SERL.	VACRS CAREWare Database ADAP Database.	Quarterly and by December 2012
	QM data reports.	Gather, interpret and present results to the QMCs, VDH and stakeholders.	VCU-SERL and QM Coordinator	VACRS CAREWare Database ADAP Database Data presentations at contractor meetings.	April/May 2012 Nov/Dec 2012 May/Jun 2013

Goal: D. Providing TA and Trainings on an ongoing basis					
AREA	**Objectives**	**Key action steps**	**Person/Agency Responsible for Collection**	**Method of Reporting/Data Sources**	**Timeline**
	Provide QM trainings for Peer Review Team, QMCs, and other stakeholders as needed	Identify topics, dates, and locations of trainings, Develop and provide training events.	VDH QM Coordinator and other resources.	Trainings developed and conducted.	Ongoing and by March 2013
	Provide QM trainings and technical assistance to providers as needed.	Identify training needs Develop training materials and Provide trainings.	VDH QM Coordinator and other resources.	Trainings developed and conducted.	By March 2013
	Develop and facilitate QM trainings/workshops for People	Identify training needs and contents from the	VDH QM Coordinator and other resources.	Trainings developed and conducted.	By March 2013

	Living with HIV/AIDS as needed.	QMCs and consumers Provide and evaluate trainings.			
	Support other QM training opportunities.	Participate in NQC web conferences, meetings, conferences, and other specific trainings (Case Managers, outreach, etc.).	All stakeholders.	Number of attended events. Number of trainees	Ongoing
	Provide ongoing technical assistance to providers.	Provides technical assistance to providers on QM Principles and any needed specific topics.	QM Leadership Team, QM Advisory Committee and HCS staff.	Number of requested technical assistances Number of technical assistance provided.	By March 2013
	ADAP	Address the training needs of ADAP stakeholders related to available programs or other clinical issues to improve the service delivery of ADAP.	The ADAP team will provide or coordinate on-site training and technical assistance.	TA provided Site visits Monthly reports Quarterly conference calls. Feedback from consumers, consortia, other contractors, planning councils, LHDs and other RW-funded providers are all modes for assessing the medication distribution system.	Ongoing and as needed
ALL grantees meeting	Hold all Grantees meeting.	Identify funding, dates, and locations for 2012 meeting.	AETCs.	Meeting report.	To be determined, pending availability of resources

Goal: E. Facilitate the implementation of QI activities across RWB funded agencies to meet annual quality goals					
AREA	**Objectives**	**Key action steps**	**Person/Agency Responsible for Collection**	**Method of Reporting/Data Sources**	**Timeline**
QI Activities	Encourage incorporating the RWB QM goals into agencies' QI activities.	Disseminate performance measure goals to all agencies.	All stakeholders VDH staff.	Written documents, face-to-face meetings, telephone, webs and emails.	Ongoing by March 2013
		Implementation of selected QI activities in agencies to meet annual goals.	All providers.	Submitted QI reports and site visit reports on monthly basis.	Ongoing by March 2013
	ADAP QA assessments of medication treatment regimens, adherence issues, and drug utilization.	Conduct 5-10 site visits (2 visits per month) and chart audits to assess the adherence status. Medication regimens.	HCS ADAP staff.	ADAP database, Site visit reports, and ADAP Eligibility Report system (AERS).	By March 2013
Peer Review	Request For Proposal (RFP) opens for bid.	Draft and release the RFP, process selection contractor and negotiate agreements	HCS staff	Released RFP and contract in place	By May 2013
	Strengthen peer review tools and process.	Review and update Standards of care and related Modules Make changes on processes to incorporate collected suggestions.	Selected contractor	Written documents, policies and procedures.	By March 2013 and as needed
	Evaluate processes and effectiveness of HIV programs.	Conduct review of selected sites including chart abstractions and data collection	Selected contractor and HCS staff.	Site visit reports Data analysis and presentation.	By March 2013
		Present annual PR report to key stakeholders.	Selected contractor and HCS staff.	End of year final report.	May 2013
QI Projects	Assure QI Projects occur at the state and local levels.	QMACs will identify needed QI projects.	HCS and selected contractor	Meeting Minutes List of identified projects and teams.	As needed by March 2013.
		Communicate findings to key stakeholders.	HCS and selected contractor	End of project summary reports.	Ongoing and by May 2013

Collaborative	The Virginia RW Cross-Part QM Collaborative.	RWB will keep working with other RW Parts to sustain Cross-Parts alignment of quality efforts in Virginia.	Services will be tracked and measured to find improved health outcomes.	All RW Cross-Parts Teams.	By March 2013
	The HRSA Patient Safety and Clinical Pharmacy Services Collaborative (PSCPS) project.	Support the EVMS PSPC Team	Eastern Virginia Medical School (EVMS), ESHD, TRHD, PharmD and HCS staff.	Meeting minutes, submitted reports, data analysis, and national recognition.	By March 2013
	The local PAMAETC performance sites and the HARCCs.	VDH will work closely with the local Pennsylvania/Mid-Atlantic AETC performance sites and the VHARCCs.	Planning educational conferences, face-to-face, or videoconferences for local ADAP Coordinators, medical providers, case managers, and other professionals working with PLWHAs.	Training reports Number of trainings and trainees	Ongoing by March 2013

TABLE 2: PERFORMANCE MEASURES

CORE CLINICAL MEASURES					
Measurement Outcome	**Indicator to be Measured**	**Data Elements used to Measure Indicator**	**Data Source & Methods**	**Analyzing & Reviewing Data**	**Data Usage**
Percent of RW clients with HIV who had 2 or more CD4 T-cell tests and Viral Load counts performed in the measurement year.	Change in the number of RW clients with HIV who had 2 or more CD4 T-cell and Viral Load counts performed in the measurement year.	**Numerator:** # of HIV-infected clients who had 2 or more CD4 T-cell counts performed at least 3 months apart during the measurement year. **Denominator:** Number of HIV-infected clients who had a medical visit with a	VACRS CAREWare Database ADAP Database Other Sources.	RW data Coordinators and Virginia Commonwealth University Survey Evaluation and Research Laboratory are responsible for reviewing data and presenting to the QMCs.	Provide data to the Macs to determine: 1) Was the goal met? 2) Should we continue track this measurement?

		provider with prescribing privileges at least once in the measurement year.			
Percent of RAW clients with AIDS who are prescribed HART.	Change in the number of RAW clients with AIDS who are prescribed HART.	**Numerator:** Number of clients with AIDS who were prescribed a HART regimen within the measurement year. **Denominator:** Number of clients who have a diagnosis of AIDS, and had at least one medical visit with a provider with prescribing privileges in the measurement year.	VICARS CARE Ware Database ADAPT Database Other Sources.	RAW data Coordinators and Virginia Commonwealth University Survey Evaluation and Research Laboratory are responsible for reviewing data and presenting to the Macs.	Provide data to the Macs to determine: 1) Was the goal met? 2) Should we continue track this measurement?
Percent of RAW clients with HIV who had 2 or more medical visits in HIV setting.	Change in the number of RAW clients with HIV who had 2 or more medical visits in HIV setting.	**Numerator:** Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, in an HIV care setting two or more times at least 3 months apart during the measurement year. **Denominator:** Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.	VICARS CARE Ware Database ADAPT Database Other Sources.	RAW data Coordinators and Virginia Commonwealth University Survey Evaluation and Research Laboratory are responsible for reviewing data and presenting to the Macs.	Provide data to the QMCs to determine: 1) Was the goal met? 2) Should we continue track this measurement?
Percent of RW clients	Change in the number of	**Numerator:**	VACRS	RW data	Provide data to the

with HIV and CD4 T-cell <200 who are prescribed PCP prophylaxis.	RW clients with HIV and CD4 T-cell <200 who will have prescribed PCP prophylaxis.	Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm3 who were prescribed PCP prophylaxis. **Denominator:** Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year, and had a CD4 T-cell count below 200 cells/mm3.	CAREWare Database ADAP Database Other Sources.	Coordinators and Virginia Commonwealth University Survey Evaluation and Research Laboratory are responsible for reviewing data and presenting to the QMCs.	QMCs to determine: 1) Was the goal met? 2) Should we continue track this measurement?
Percent of RW Clients with HIV infection who received testing with results documented for latent Tuberculosis infection (LTBI) since HIV diagnosis.	Change in the number of RW Clients with HIV infection who received testing with results documented for latent Tuberculosis infection (LTBI) since HIV diagnosis.	**Numerator:** Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis. **Denominator:** Number of HIV-infected clients who: ▪ do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and ▪ had a medical visit with a provider prescribing privileges at	VACRS CAREWare Database ADAP Database Other Sources.	RW data Coordinators and Virginia Commonwealth University Survey Evaluation and Research Laboratory are responsible for reviewing data and presenting to the QMCs.	Provide data to the QMCs to determine: 1) Was the goal met? 2) Should we continue track this measurement?

		least once in the measurement year.			
Percent of RW Clients with HIV infection (18 years or older) who had a serologic test for syphilis performed at least once during the measurement year.	Change in the number of RW Clients with HIV infection (18 years or older) who had a serologic test for syphilis performed at least once during the measurement year.	**Numerator:** Number of HIV-infected clients (18 years or older) who had a serologic test for syphilis performed at least once during the measurement year. **Denominator:** Number of HIV-infected clients ▪ 18 years or older or ▪ had a history of sexual activity <18 years and ▪ had a medical visit with a provider with prescribing privileges at least once in the measurement year.	VACRS CAREWare Database ADAP Database Other Sources.	RW data Coordinators and Virginia Commonwealth University Survey Evaluation and Research Laboratory are responsible for reviewing data and presenting to the QMCs.	Provide data to the QMCs to determine: 1) Was the goal met? 2) Should we continue track this measurement?
ADAP	Percentage of ADAP clients with AIDS who were prescribed a HAART regimen within the measurement year.	**Numerator:** Number of ADAP clients with AIDS who were prescribed a HAART regimen within the measurement year. **Denominator:** Number of ADAP clients with a provider with prescribing privileges in the measurement year.	ADAP Database Other Sources	HCS and Virginia, PSI and SERL are responsible for reviewing data and presenting to the QMCs.	Provide data to the QMCs to determine: 1) Was the goal met? 2) Should we continue track this measurement? 30 Make needed changes
	Percentage of ADAP clients who complete at least one eligibility determination through the centralized	**Numerator:** Number of ADAP clients with at least one eligibility determination	ADAP Database AERS.	HCS and Virginia, PSI and SERL are responsible for reviewing data	Provide data to the QMCs to determine: 1) Was the goal met? 2) Should we continue

	eligibility determination system.	with PSI. **Denominator:** Number of ADAP clients seen in the measurement year.		and presenting to the QMCs.	track this measurement? 3) Make needed changes
Medical Case Management	Percentage of RW HIV-infected medical case management clients who had 2 or more medical visits in HIV care setting in the measurement year. **Retention in Care (Medical Visits)**	**Numerator:** Number of medical case management clients who had a medical visit in an HIV care setting two or more times at least 3 months apart during the measurement year **Denominator:** Number of medical case management clients who had a medical visit at least once in the measurement year Exclusions: Those newly-enrolled during the last 6 months of the year	VACRS CAREWare Database ADAP Database Other Sources.	RW data Coordinators and Virginia Commonwealth University Survey Evaluation and Research Laboratory are responsible for reviewing data and presenting to the QMCs.	Provide data to the QMCs to determine: 1) Was the goal met? 2) Should we continue track this measurement?
	Percentage of RW HIV-infected medical case management clients with AIDS who were prescribed a Highly Active Antiretroviral Therapy (HAART) regimen within the measurement year. **Treatment (HAART)**	**Numerator:** Number of medical case management clients with AIDS who were prescribed a HAART regimen within the measurement year **Denominator:** Number of medical case management clients who have a diagnosis of	VACRS CAREWare Database ADAP Database Other Sources.	RW data Coordinators and Virginia Commonwealth University Survey Evaluation and Research Laboratory are responsible for reviewing data and presenting to the QMCs.	Provide data to the QMCs to determine: 1) Was the goal met? 2) Should we continue track this measurement?

		AIDS (CD4 count ever below 200 or other ADC) and had at least one medical visit in the measurement year **Exclusions:** Those newly enrolled in care during the last 3 months of the year.			
	Percentage of RW HIV-infected medical case management clients with a viral load below 200 at last test during the measurement year. **Outcomes (Viral Load Suppression)**	**Numerator:** Number of medical case management clients with a viral load below 200 at last test during the measurement year **Denominator:** Number of medical case management clients aged 13 and over who were HIV+ and had at least one medical case management visit in the measurement year and were prescribed ARV for at least 6 months and had a viral load test during the measurement year.	VACRS CAREWare Database ADAP Database Other Sources.	RW data Coordinators and Virginia Commonwealth University Survey Evaluation and Research Laboratory are responsible for reviewing data and presenting to the QMCs.	Provide data to the QMCs to determine: 1) Was the goal met? 2) Should we continue track this measurement?

ACRONYMS

ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AERS	ADAP Eligibility Reporting System
AIDS	Acquired Immune Deficiency Syndrome
AOS	ADAP Operations Specialist
ART	Antiretroviral Therapy/Treatment
CARE Act	Comprehensive AIDS Resources Emergency Act
CQI	Continuous Quality Improvement
DDP	Division of Disease Prevention
DHHS	Department of Health and Human Services
DMAS	Department of Medical Assistance Services
eHARS	Enhanced HIV/AIDS Reporting System
HAART	Highly Active Antiretroviral Therapy
HAB	HIV/AIDS Bureau
HARCC	HIV AIDS Resource and Consultation Center
HCS	HIV Care Services
HERR	Health Education/Risk Reduction
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for People With AIDS
HRSA	Health Resources and Services Administration
IGRA	Interferon Gamma Release Assay
LPS of the	
LTBI	Latent Tuberculosis Infection
OEPI	Office of Epidemiology
PA/MA ETC	Local Performance Site of the Pennsylvania/MidAtlantic AIDS Education & Training Center
NASTAD	National Alliance of State and Territorial AIDS Directors
NQC	National Quality Center
PDSA	Plan, Do, Study and Act
PCP	Pneumocystis Carinii Pneumonia
PJP	Pneumocystis Jiroveci Pneumonia
PLWHA	Person Living with HIV/AIDS
PSI	Patient Services Incorporated
PSPC	Patient Safety and Clinical Pharmacy Services Collaborative
PHS	Public Health Services
QA	Quality Assurance – A broad spectrum of evaluation activities aimed at ensuring compliance with minimum quality standards
QI	Quality Improvement – Activities aimed at improving performance
QIPT	Quality Improvement Project Teams
QM	Quality Management
QMAC	Quality Management Advisory Committee
QMLT	Quality Management Leadership Team
RW	Ryan White
RWB	Ryan White Part B
SERL	Survey Evaluation and Research Laboratory
SPNS	Special Projects of National Significance

TA	Technical Assistance
TST	Tuberculin Skin Test
VACRS	Virginia Client Reporting System
VDH	Virginia Department of Health
VHARCC	Virginia HIV/AIDS Resource and Consultation Center